Phone: (406) 290-9788 Elizabeth@ElizabethKennard.com Fax: (406) 215 - 9744

AUTHORIZATION TO RELEASE INFORMATION

Please note: If you are a recipient of information released by Elizabeth Kennard, PLLC the following Federal Law applies directly to you: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (45 CFR Part 160 and 164, and 42 CFR Part 2) prohibit you from making any further disclosure if it is without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

Client's Name: ___________________________ Date of Birth: ____/____/____ SSN: ______/______/______

RELEASE TO: ☐ OBTAIN FROM: ☐

Agency/Name(s): ____

Role: ☐ Case Manager ☐ Medication Provider ☐ CSCT Therapist ☐ Addiction Therapist ☐ Other

Address: ____

Phone: (________)___________________________________ Fax: (________)_______________________

INFORMATION TO BE RELEASED/OBTAINED (CHECK BOX):

☐ history and physical
☐ diagnosis
☐ intake/discharge summary
☐ chemical dependency evaluation
☐ dates of treatment attendance
☐ verbal exchange regarding patient care
☐ psychiatric evaluation/records
☐ psychological evaluation
☐ medical evaluation/records
☐ progress report/periodic treatment review
☐ school records (IEP, 504, Behavior Reports, Grades, Attendance)
☐ other (specify): ____

THE PURPOSE OR NEED FOR SUCH DISCLOSURE IS:

☐ for ongoing mental health services and support
☐ other (specify): ____

This authorization is valid for a two year period from the date of signature, unless this form contains specification of a Date, Event or Condition upon which this consent expires: ____

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not. I understand that this information will not be disclosed to anyone other than those persons participating in my treatment continuum without my written permission. I understand that I have a right to inspect and obtain a copy of any information disclosed pursuant to this authorization. I understand that disclosed information may be re-disclosed to additional parties and no longer protected once the person(s) listed above receive my child's health information. I understand that I may revoke this authorization at any time.

Peaks & Valleys Therapy, PLLC and its employees are hereby released from any legal responsibility or liability for disclosure of the above information the extent indicated and authorized herein. I authorize the use of a fax or photocopy of this form for the release or disclosure of the information described above.

Client/Guardian Signature: ____ Date: _______________________

REVOCATION SECTION:

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Elizabeth Kennard, SWLC, at Elizabeth Kennard, PLLC. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.
I hereby revoke this authorization:
Signature: ____ Date: ___________________